



**BlueCross
BlueShield**

Federal Employee Program.

RHAPSIDO PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn: Clinical Services
Fax: **1-877-378-4727**

Patient Information (required)				Provider Information (required)			
Date:				Provider Name:			
Patient Name:				Specialty:		NPI:	
Date of Birth:		Sex: ☒ Male ☐ Female		Office Phone:		Office Fax:	
Street Address:				Office Street Address:			
City:		State:		Zip:			
Patient ID: R				Physician Signature:			
PHYSICIAN COMPLETES							

Rhapsido (remibrutinib)

**Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ☐ Brand ☐ Generic

1. Will the patient need more than 50 milligrams per day? ☐ Yes* ☐ No

**If YES, please specify the requested milligrams per day: _____ mg per day*

2. Does the patient have a diagnosis of chronic spontaneous urticaria (CSU)? ☐ Yes ☐ No

3. Will the patient be given live vaccines while on this therapy? ☐ Yes ☐ No

4. Will this medication be used in combination with another monoclonal antibody for the treatment of CSU? ☐ Yes* ☐ No

**If YES, please specify the medication(s): _____*

5. **Blue Standard Patient:** Is this medication being requested as a change from Dupixent? ☐ Yes ☐ No

6. **Blue Basic / Blue Focus Patient - Please answer the questions below:**

a. This is a non-formulary medication. Please provide all formulary alternative medication(s) that have been tried and failed and specify the medical record page number(s) below:

☐ **PAGE(s)** _____ **of** _____ *(Please ensure that all relevant medical records are submitted)*

Formulary alternative medication(s): _____

☐ **The patient has not tried and failed any formulary alternatives.**

b. Would you like to switch to the preferred medication? The preferred medication is Xolair. ☐ Yes* ☐ No

**If YES, does the prescriber agree to review the plan criteria associated with the requested preferred medication to ensure that the medication is safe and appropriate for the patient?* ☐ Yes ☐ No

7. Has the patient been on this medication continuously for the last **6 months** excluding samples? *Please select answer below:*

☐ **NO** – this is **INITIATION** of therapy, please answer the following question:

a. Does the patient have a baseline *urticarial activity score (UAS)? ☐ Yes* ☐ No

**If YES, please specify score: _____*

**Urticarial Activity Score: <https://www.mdcalc.com/urticaria-activity-score-uas>*

b. Has the patient remained symptomatic after at least **TWO** previous trials of H1-antihistamines? ☐ Yes ☐ No

☐ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient's urticaria activity score (UAS) decreased, such as improvement in pruritic wheals, hives, and itching? ☐ Yes* ☐ No

**If YES, please specify score: _____*

**Urticarial Activity Score: <https://www.mdcalc.com/urticaria-activity-score-uas>*